Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOTEXAS PHYSICIANS & SURGEONS
4780 NORTH JOSEY LANE
CARROLLTON TX 75010

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-13-1247-01

MFDR Date Received
JANUARY 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On this date of service, you denied procedure code 29875 inclusive to another procedure, which is incorrect. There are three compartments of the knee: lateral, medical [sic], patella-femoral. The operative details the synovectomy was performed in the patellar section of the knee. The meniscectomy was performed in the lateral section of the knee. The meniscal part was performed in the medical [sic] section of the knee."

Amount in Dispute: $1,311.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2012	CPT Code 29875-59-RT	$1,311.00	$169.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits (EOBs)

- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Is the requestor entitled to reimbursement for CPT code 29875-59-RT?

Findings

1. The respondent denied reimbursement for CPT code 29875-59-RT based upon EOB denial reason code "97."

   CPT code 29875 is defined as "Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)."

   On the disputed date of service the requestor billed CPT codes 29881-59-RT, 29882-RT and 29875-59-RT.

   The respondent paid for CPT codes 29881 and 29882.

   CPT code 29881 is defined as "Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed)."

   CPT code 29882 is defined as "Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)."

   Per NCCI edits CPT code 29875 is a component of CPT code 29881 and 29882; however, a modifier is allowed when appropriate. The requestor utilized modifier "59" to differentiate it as a separate service.

   Modifier 59's descriptor is "**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-Evaluation and Management (E/M) services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used."

   The August 29, 2012 Operative report indicates that the claimant underwent "Diagnostic arthroscopy, right knee; Retropatellar decompression with partial fat-pad excision and anterior synovectomy; Shaving chondroplasty of the medial femoral condyle; Partial anterior horn lateral meniscectomy; and Medial meniscal repair using multiple Smith & Nephew internal fixation meniscal repair devices."

   The Division finds that the requestor has supported the use of modifier 59 and billing of CPT code 29875 because performed in a separate compartment of the knee; therefore, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

CPT code 29875, 29881and 29882 have a multiple surgery payment indicator of "3." A payment indicator of "3" is defined as "Endoscopic criteria applies."

To determine reimbursement for endoscopic procedures in the same family, the CMS policy manual states "When multiple procedures are performed through the same endoscope, payment will be made for the highest valued endoscopy (100% of the allowance) plus the difference between the next highest and the base

endoscopy."

CPT codes 2988, 29882 and 29875 are in the same endoscopic family and the base endoscopy code is 29870.

The Medicare fee schedule for 29870 in Plano, TX is $410.74.

The Medicare fee schedule for code 29875 in Plano, TX is $494.35.

Per the endoscopic policy, the basic endoscopic allowance of $410.74 is deducted from the allowance of $494.35 = $83.61.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2012 DWC conversion factor for this service is 68.88.

The Medicare Conversion Factor is 34.0376

Using the above formula, the MAR is $169.17.

The respondent paid $0.00. The difference between the total allowable and amount paid is $169.17; this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $169.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $169.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/15/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.